



South Shore Physician Hospital Organization

"Dedicated to the preservation of quality and value in patient care."

May 25, 2012

Aron Boros, Commissioner
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

RE: Testimony on Health Care Provider and Insurer Cost and Cost Trends

Dear Commissioner

Thank you for the invitation to provide written testimony to the Division of Health Care Finance and Policy (DHCFP) as outlined in your May 9, 2012 letter and pursuant to M.G.L. c. 118G Section 6 ½. Enclosed please find the requested responses.

Please do not hesitate to contact me at 781-624-8472 with any questions or if you require additional information.

Sincerely

Robert J. Ward
Director of Operations, Managed Care and Analytics
South Shore PHO

Thank you for inviting South Shore PHO to provide testimony on this important and complex issue.

Questions listed in Exhibit B - DHCFP

Hospitals & Other Providers

Trends in Premiums and Costs

1. **After reviewing the preliminary reports, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.**

The May 2012 Massachusetts Health Care Cost Trends Preliminary Report (the "Report") reflect tremendous efforts by DHCFP and the health care community, including health plans, to provide complex data for your analysis. DHCFP should be commended for this process of encapsulating this data and differing views on what that data truly represents into a single report.

Given the level of complexity of the Reports which contain detailed data and analyses across a wide variety of topics and the short time frame to provide this response, it is not possible for South Shore Physician Hospital Organization, Inc. ("SSPHO") to complete a comprehensive review, analysis, and response to the reports. We cannot represent that we have commented on every finding on which we might have a differing perspective. The terminology used in the Reports has nuances that may mean different things to different people, and we have made certain assumptions about the intended meaning of these terms in our responses.

Generally, the overall findings on premium trend and total medical expense (TME) are in line with what we would expect to see. It is interesting to note that total claims expenditures has slowed in more recent periods. It will be interesting to see if that trend continues and what the driving factors, other than unit price, behind this trend are; the recession, the "buy down" of benefits, improvements in quality, and more preventive care may all be factors.

We have reviewed the TME portion of the Report and provide some potential explanations for why our presumed market as defined by the Report (Southeastern Massachusetts) would have higher medical costs:

We were not able to independently validate the SSPHO chart data published on Pages 11, 12, and 13 of Appendix A to the Report due to the short time frames and the need for a better understanding of the methodology employed by DHCFP. To the best of our analysis, in reviewing the risk settlements and other payments received by the SSPHO for Calendar Year 2010, our total PMPM TME, with the inclusion of all quality, management, and other payments from the plans, did not reach the reported TME for SSPHO as reflected in the above-referenced charts. One possible explanation is that the Report appears to exclude the pediatric populations for some provider groups but not all. (Appendix B, Page 5 and Footnote 5). In 2012, SSPHO's pediatric patient population is close to 32% of our total patient panel. In 2010 our percentage of pediatric patients was over 38%. It is not clear if SSPHO's TME as recorded in the chart data reflects the adult population only, or the entire risk pool. As you are no doubt aware, the

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pediatric population has a lower health status adjustment factor, and the removal of this population from our data would increase the reported adjusted TME.

Our primary community hospital is South Shore Hospital (SSH). SSH is a regional referral center, which is an unusual designation for community hospitals in Massachusetts. As such, SSH offers a service mix at a higher level of acuity, not usually associated with the community setting. Some of these services are the neonatal ICU and high level cardiovascular services. SSH is affiliated with a number of tertiary hospitals for the delivery of cancer care, pediatrics and surgical services in the community setting.

We also note that the Report reflects a smaller proportion of large employers in SE Mass than in other areas of the Commonwealth. Large employers in SSPHO's market include municipalities and hospitals. Municipalities traditionally have a higher health care expense. The smaller proportion of large employers skews our market's data toward residents who are insured by small group or individual policies, which tend to have higher than average premiums. These small employers may not have employee health (wellness) programs or be able to support similar programs that improve employee's health (smoking cessation; health fairs; weight loss support, etc.) and potentially help to decrease TME.

2. What specific actions has your organization taken to reduce the cost of services? Please also describe what impact, if any, these strategies have had on service quality and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?

Historically, SSPHO has accepted the state wide standard physician fee schedules offered by the health plans without a multiplier to help keep unit costs low, while participating in risk arrangements. That approach keeps the unit cost low in the outpatient setting. The presence of higher cost providers outside of SSPHO's network of participating providers, who render services to our risk members, is an ongoing issue in managing our risk arrangements from an efficiency perspective.

SSPHO's risk contracts are structured on a global capitation budget against which claims are paid. In 2012, SSPHO entered into an agreement with one health plan to reduce the global capitation budget by a material percentage over the next three years. To achieve that budget target, SSPHO has embarked on a number of cost reduction strategies. Key initiatives include improved reporting to track that appropriate care is being delivered at the right location, using community providers when clinically appropriate and tertiary level providers only when necessary, and negotiating discount arrangements with selected high cost providers that include quality and clinical improvement elements. Also, SSPHO is planning a referral management program. SSPHO is also working with certain tertiary providers on programs to keep care local and to establish a quality review program that maintains the high level of quality the public deserves and SSPHO aims to deliver. SSPHO was recognized by Governor Deval Patrick in February 2011 for achieving the best overall quality scores in ambulatory measures under the Blue Cross and Blue Shield of Massachusetts (BCBSMA) Alternative Quality Contract.

SSPHO has a high penetration of electronic health record systems in our physician network. Other initiatives that SSPHO plans to undertake include establishing or improving electronic interface with clinical providers to maximize the capability of the community's electronic medical records. The costs for smaller physicians groups of building and maintaining these interfaces are significant, and may be a significant barrier to establishing a true integrated health record.

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SSPHO maintains a formulary that seeks to encourage the use of lower cost alternative medications. Presently the overall use of generic medications within SSPHO's physician network is 75%. Formulary compliance is monitored and additional provider education is provided as needed.

We have also implemented a data warehouse system with sophisticated reporting tools. While this is a new initiative, having gone live in early 2012, we anticipate better reporting to providers on the cost of care with comparisons to benchmarks. We provide data concerning the relative cost of service, by service and site, and communicate the data to our participating physicians.

Incentives related to efficiency goals are included as part of primary care physician (PCP) surplus distribution criteria. SSPHO also works with South Shore Hospital (SSH) Hospitalists and the SSH Emergency Department staff to improve transitions of care with the goal of preventing re-admissions and duplication of efforts.

Some of the limiting factors for execution of the strategies discussed above could include patient requests for services at tertiary facilities when the clinical factors in the case do not support it, and the presence of two tertiary level providers on or adjacent to the SSH campus which encourages patients to demand access to these specialists when the clinical factors in the case do not support it. At times, factors other than the clinical indications that support community level care, may take precedence with respect to where care is delivered. This includes the patient's and the patient's family's desire to get what they perceive as "the best care" for the patient/family member in an acute medical situation, which is often tied to the prestige of the tertiary academic medical centers. We suggest that better education by the Commonwealth and the health plans on the need to keep care local when medically appropriate would greatly assist in this regard. In addition, the health insurance industry may have specific suggestions on how to encourage this concept through benefit design. We note that the tiered networks in the Commonwealth Choice products appear to be having the desired effect in this regard.

Behavior change of this nature is difficult and takes time to accomplish. Meaningful reduction in the cost of services will require a significant modification of behavior by all participants in the health care delivery system, including providers, health plans, the government, and the general population. All parties must work together to improve health literacy.

3. When calculating Total Medical Expense (TME), we found a wide variation in health-status adjusted TME by provider group and that a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please share your organization's reaction to these findings.

As noted in the response to Question 2 above, densely populated areas with close proximity to a regional referral center and/or community-based tertiary centers (such as advanced cancer care or specialty pediatric care) will often result in patients seeking services at those locations, even if lower-cost, equal quality services are otherwise available. It appears that there is still a public perception that services are of a higher quality if performed at tertiary centers. Patients often demand that higher cost service during an acute care incident, and discussion with local providers about alternative, non-tertiary providers could result in the patient and/or family experiencing negative feelings toward their local providers.

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While sophistication in health status adjustment methodologies (such as Ingenix and DxCG) is improving, these methodologies may not accurately and fully reflect actual TME. This is because, in our view, accurate coding does not always fully reflect all elements of care for patients with complex conditions, and thus does not fully capture the true costs associated with such care.

In addition, in our view, under-coding by providers continues to be an issue and is difficult to adjust for in the health status adjustment models. For example, despite offering PCPs information and assistance to code accurately, we have found that a large percentage of our risk members identified with diabetes by BCBSMA were assigned the 250.00 code (well controlled diabetes) by the treating providers, while in fact many had more complicated presentations that would have supported a higher code or disease complications that were not fully captured.

Further, we noted that there is a paucity of hierarchical conditional coding (HCC coding) options for pediatric patients and that contributes to a less refined health status adjustment factor in that population. Cancer care coding for pediatric patients may serve as an illustrative example of this. Cancer care has become increasingly costly and is occurring with increasing frequency solely in the outpatient setting. With a relatively younger population, second, third and fourth line therapies are more commonly applied. As noted earlier, one third of SSPHO's risk members are pediatric patients.

4. Please explain the main factors for any changes in annual TME that your organization has experienced. What specific efforts has your organization made to lower or reduce the growth in TME? What has been the result of such efforts?

The tension between providing high quality care and reducing TME has been a challenge for our providers due to the proximity to the Boston market and the density of physician providers affiliated with tertiary institutions who practice in our market, even on a limited basis.

We have described our TME reduction approaches in Question 2. The results in 2011 were not as robust as SSPHO had hoped for, prompting SSPHO to review those strategies and make some enhancements. We are creating better reporting to track TME using the data warehouse which went live in 2012. This information should help us identify high quality, low cost community providers to assist in lowering TME. SSPHO has entered into a risk contract with one payer which specifically focuses on TME reduction over a three year period concluding at the end of 2014. It includes incentives to achieve those results. We intend to move in a similar direction in our other payer contracts as they come up for renewal.

Health System Integration

5. How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.

SSPHO and its participating providers, through the existing risk arrangements SSPHO participates in, are accountable for the cost and quality of the care our providers render and thus, currently operate to some degree as an ACO.

a. Is your organization participating in the Medicare Shared Savings ACO project?

SSPHO is not participating in the Medicare Shared Savings Program at this point. We are exploring this possibility, and believe we need to refine our infrastructure to fully support a Medicare Shared Savings Program undertaking. Also, we note that SSPHO has a high percentage of pediatric patients who would not be included under a Medicare Shared Savings ACO.

b. If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?

Until recently SSPHO did not have a data warehouse to aggregate the claims history of our risk patients. We believe this capability and the ability to analyze and report the data is essential to an ACO. In addition, to join or form an effective ACO, SSPHO would need to establish clinical relationships with providers across the continuum of care and complete its work on information technology platforms that would allow the electronic flow of critical clinical information and progress notes. SSPHO believes that the prospective or real time identification of patients participating in the ACO is critical for the successful functioning of the ACO. We believe that models that allow for retroactive attribution or allow patients to opt in or opt out of the ACO with few restrictions will negatively impact the ability of the primary care provider to establish a relationship with the patient and implement an effective care management plan, which could in turn affect the ability of the ACO to successfully manage cost and quality.

The significant infrastructure cost to develop and maintain a viable ACO is a significant concern. Funding in the form of grants, government-backed loans, and/or enhanced infrastructure payments from the health plans would lessen the business risk in developing an ACO. Alternatively, becoming part of a larger network for purposes of ACO program participation may provide access to the required resources at a lower cost.

6. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, patient outcomes and your organization's performance?

SSPHO participates in global capitation arrangements with health plans including the BCBSMA Alternative Quality Contract (AQC). Under the AQC, our quality scores have continued to increase. This improvement in quality scores, which is based on an amalgamation of process measures, outcomes and patient experience data, should have the effect of reducing the cost of care over the long term. We would expect our efforts towards meeting these quality measures to result, in the long-term, in a lower prevalence of chronic disease conditions and/or delay in the onset and progress of such conditions.

SSPHO faces constant pressure to meet quality measures and reduce the cost trend. We believe that one of the major components in driving the cost trend down and meeting quality goals is directing care to high-quality, lower-cost providers in the market. We are expanding reporting to our physicians of patient data and analysis to assist our providers in understanding actual trends and making real-time, evidence-based, care management decisions. In our experience, health plans do not currently share overall health status adjusted network costs that would give us benchmarks to identify areas of focus. Providing the costs of other groups in an appropriate manner would be very beneficial for transparent comparison of costs among

networks and identification of areas for continued improvement, as well as identifying best practices.

7. Please comment on how your organization is developing formal arrangements or affiliations with other health care providers to provide care under global contracts or other alternative payment methods.

SSPHO has begun to strengthen the existing formal arrangements with selected tertiary providers to improve communication and coordination of services with the goals of avoiding duplication of testing and keeping the care within the community, where appropriate. We are reviewing possible opportunities with urgent care centers in our area to reduce emergency department utilization when appropriate. We have also identified lower cost imaging providers in the local community as an option for our participating physicians. We are also exploring possible affiliation arrangements with other networks.

8. What have been the effects of the recent proliferation of limited or tiered network plans on your organization, with regard to how you evaluate performance internally and patient access to care?

SSPHO believes that limited and tiered networks, if properly designed, can exert a strong influence on the cost of care. We believe an issue with most of these products as implemented in this market, is the appropriate weighting of the cost component to the quality component. Tiering should in our view distinguish between high cost providers while also identifying high quality providers based on objective and transparent data. The effect on our organization is difficult to determine at this time since the tiered products have only recently been introduced in our market. Anecdotally, some of our provider members have reported that patients in limited or tiered network plans have requested referrals to lower cost providers or have commented that they are contemplating leaving a practice, but a broader effect has not been quantified.

9. Given the proliferation of risk contracting, to what extent is your organization participating in global contracts that include “atypical” healthcare providers (e.g., behavioral health, oral health, home health care, etc.)? If your organization participates in a risk contract, how are supporting services, such as behavioral health and home health care, addressed?

SSPHO participates in global budget contracts which generally exclude from the budget certain services such as mental health and oral care. We do not take risk under these contracts on behavioral health services due to the lack of mental health providers in the area and the absence of a local inpatient unit for mental health. Generally, patients with mental / behavioral health service needs present very complex cases, and without a sufficient number of local, qualified professionals to treat these members, we rely on the health plans' programs to manage those types of services and costs. While at risk for home health services under our risk arrangements, we rely on the applicable health plan's policies and network of home health care agencies to help with the appropriate utilization of those services.

10. Are there specific areas of care for which you believe there are critical gaps in quality measurement?

In SSPHO's view, quality measurement presents particular challenges with respect to the professional services provided by specialists. There are, what we consider to be, weak proxies for measuring quality for some specialties, mainly procedural and outcomes-based measures.

We believe it is critical for the medical specialty colleges to create and publish reliable quality population-based criteria for its members to use to improve care. Such criteria could be outcomes-based or simply administrative-focused, which could help to reduce unnecessary referrals (e.g., criteria related to how often/under what circumstances a specialist should seek another opinion). We also see a real need for the development of more pediatric outcome measures. Most existing pediatric quality measures tend to focus on areas where pediatricians are, generally, traditionally high performing in Massachusetts and don't tend to target high cost areas.

In our view, it is important to emphasize that quality metrics must be measurable, meaningful and actionable. There is an associated cost that must be considered as well, and standardization of metrics would alleviate the cost burden that results when there are similar measures in place for different health plan contracts, but with slightly different benchmarks, measurement periods and/or reporting criteria. To the extent the state and health plans could work together to create meaningful, standard quality metrics that are uniformly applied by all payers, it would reduce provider administrative expenses. The Massachusetts Health Quality Partnership is a good example of productive cooperation in this regard.

11. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

As premiums continue to rise faster than the state gross domestic product, as the Report suggests, and TME continues to outpace inflation, there is perhaps a natural tendency to seek regulatory as opposed to market-based solutions. Effectively addressing this problem will require not only the cooperation and support of the health providers, but also that of the health insurance industry, employer groups and the general population, with patients taking on an active role in managing their health. It appears to us that any solution must include modifying the deeply ingrained expectations of many patients that they should have unrestricted choice of provider, and that more health care is better health care. Patients need to engage in their personal care and weigh quality against cost in every health care interaction.

In our view, the administrative complexity of the current system adds cost for providers, employers, and patients. In our experience, monitoring the different clinical, administrative and payment policies that the health plans implement--overlaid with the expanding number of insurance products, some with unique requirements--adds significant administrative costs for the providers and frustrates patients, who often do not fully understand the product they or their employer has selected. An objective review of how beneficial health plan policies and plan designs are in reducing cost and improving outcomes and quality would, we believe, be useful. More beneficiary education by employers and health plans to assist beneficiaries in understanding the terms and conditions of their coverage would also be useful in reducing confusion and frustration and encouraging consumer engagement in important decisions about their care and the selection of their health insurance product.

Office of the Attorney General – Exhibit C

1. If you have entered a contract for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any “downside” risk (hereafter “risk contracts”), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to improve your opportunities for surpluses under such contracts, such as any changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO v. PPO, fully-insured v. self-insured) on your opportunities for surpluses.

SSPHO employs an array of practices to improve performance under our risk contracts by reducing the cost of care, while maintaining or improving quality. The current nature of our risk agreements limits us to the HMO population. While the following is not an all-inclusive listing of such initiatives, it does represent some of our recent initiatives:

- Unit cost reduction through contract strategies with health plans and selected tertiary and community partners (e.g., arrangements for discounted rates for risk members that include quality and clinical components);
- Inpatient cost reduction / quality improvement through referral management processes focused on decreasing utilization of tertiary facilities as medically appropriate and keeping care in the community, reducing re-admission rates by improving communication between PCPs and hospitalists, and review of short stay admissions to identify potential opportunities;
- ED utilization reduction by enhancing PCP access (office hours) and exploring urgent care opportunities;
- ED cost reduction / quality improvement through enhancements in the care transition process;
- Outpatient cost reduction through increased utilization of local in-network specialists;
- Outpatient cost reduction / quality improvement by decreasing specialist re-referral through improved communication to set specific expectations and implementation of standard communication processes & protocols;
- Management of imaging utilization and unit cost through use of lower cost community providers; and
- Continuing clinical integration initiatives, including: adoption of new, and evaluation of existing, evidence-based clinical pathways with dissemination and integration into the EMRs of participating practices; utilization of SSPHO’s data warehouse to identify additional opportunities to blunt the impact of high cost and/or high utilization services; development of interfaces to import data from practice EMRs into the clinical data warehouse.

We are also exploring opportunities to collaborate with community providers (such as laboratories and hospitals) in meaningful projects to “bend the trend” (for example, possible initiatives include creating a low back pain program, investigating better joint replacement processes, and collaborating to create a headache care model with a tertiary center to reduce cost on the care continuum.)

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In addition to these initiatives, we have focused on enhanced reporting and regular meetings with PCPs, specialists and certain hospitals we work closely with to identify potential community-based cost reduction solutions and opportunities to improve quality.

SSPHO has seen an ongoing reduction in its covered lives under its risk contracts. Generally, we observe that patients are not leaving our participating practices but, rather, are switching to unmanaged products or self-insured arrangements, some of which have no PCP gatekeeper requirements. This appears to be reflected in a general loss of HMO membership reported by the health plans and the corresponding growth of PPO products.

2. Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

SSPHO develops regular reports that are reviewed by the SSPHO Board on performance under each risk arrangement. These reports include progress on the quality initiatives and the status of initiatives designed to reduce total medical expense and/or increase quality. On an annual basis, SSPHO re-evaluates its need for stop loss insurance through analysis of historical stop loss claims. Historically, SSPHO has had provider withholds in place to protect against loss, but we are observing that the health plans are moving away from withholds and towards other types of protections against loss, primarily stop-loss coverage. We have never experienced a deficit in a risk contract but regularly evaluate current and projected performance to anticipate and plan for a deficit scenario, including the possible need for reserves.

3. Please explain and submit supporting documents that show (a) any effect of tiered or limited network products on your volume or business and (b) any changes you have made, or plan to make, to your business practices as a result of tiered or limited network products. Include in your response any effect of tiered or limited network products on your patient referral practices, or how you contract with health plans.

Please refer to the Response to Question 8 in the written testimony submitted to DHCFP by SSPHO. SSPHO has not quantified the effect of limited and tiered networks on our organization's volume or business. Because these products include total medical expense in the tiering methodology, we believe these benefit designs provide an incentive to continue TME reduction initiatives.

4. Please explain and submit supporting documents that show how implementation of value-based payment provisions of the federal Patient Protection and Affordable Care Act (e.g., bundled payments, shared savings, accountable care organizations, and other value-based payments) has affected your business practices, including any changes you have made, or plan to make, to your physician recruitment or patient referral practices.

We are still evaluating the risks and benefits of participation in these types of value-based payment models. This potential shift in reimbursement models and the quality focus inherent in some of these models has prompted internal discussion on how to expand access to key specialists.

5. Please submit a summary table showing your advertising/marketing budget and costs for each year 2008 to present. Please explain and submit supporting documents that show the methodology you use to determine your advertising/marketing budget and costs.

SSPHO's provider relations area serves a marketing role in engaging in outreach to new physician members and maintaining existing relationships. SSPHO maintains a website where participating physicians may access useful information and where patients may locate contact information for participating physicians. SSPHO organizes an Annual Meeting which serves as an educational forum for our participating physicians, and where token gifts with the SSPHO logo are distributed.

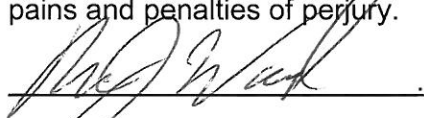
<i>FY 2008 - 2011, FY2011 Preliminary</i>	2008	2009	2010	2011
Total Marketing & Advertising Expense	\$392,533	\$235,987	\$228,004	\$199,804

6. Please explain and submit supporting documents that show (a) trends since 2008 in the proportion of bad debt, as defined by M.G.L. c. 118G, § 1, you carry on your total business, (b) your understanding of the factors underlying these trends in bad debt, including but not limited to any role of health insurance plan design, and (c) any changes you have made to your debt collection policies, practices, or expectations in light of these trends.

As a physician-hospital organization, this question does not apply to SSPHO.

ATTESTATION

I, Robert J. Ward, am legally authorized and empowered to represent South Shore Physician Hospital Organization, Inc. for the purposes of this testimony, and this testimony is signed under pains and penalties of perjury.



Robert J. Ward
Director of Operations, Managed Care and Analytics
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